TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Service Lloyds Insurance Co.

MFDR Tracking Number
M4-24-1014-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
January 11, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 31, 2023	97110-GP	$346.86	$263.89
August 31, 2023	97112-GP	$132.76	$116.29
September 6, 2023	97110-GP	$346.86	$263.89
September 6, 2023	97112-GP	$132.76	$116.29
September 7, 2023	97110-GP	$346.86	$263.89
September 7, 2023	97112-GP	$132.76	$116.29
September 11, 2023	97110-GP	$346.86	$263.89
September 11, 2023	97112-GP	$132.76	$116.29
September 12, 2023	97110-GP	$346.86	$263.89
September 12, 2023	97112-GP	$132.76	$116.29
	Total	$2,398.10	$1,900.90

Requestor's Position

"These bills still remain unpaid. There has never been a response of denial or payment for these bills."

Amount in Dispute: $2,398.10

Respondent's Position

"In response to the MFDR received on 01/18/2024 for date of service 08/31/2023-09/12/2023 please note the following as current denial stands: The provider submitted the UR request for 12 physical therapy sessions for the [body area] ordered from the 8/28/23 doctor exam and they were certified with UR #.... The DOS 08/31/2023-09/12/2023 in question have notes referencing therapy to both the [body area] and the [body area], therefore bills have been denied based on 'no authorization'. The provider did not request therapy for the [body area], only the [body area]."

Response Submitted by: Mitchell International, Inc.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.
3. 28 TAC §134.600 sets out the preauthorization guidelines for specific treatments and services.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 230 – Treatment not authorized.
- 242 – Services not provided by network/primary care providers.
- Denial reason note: "UTILIZATION REVIEW ONLY AUTHORIZED TREATMENT FOR THE [BODY AREA]."

Issues

1. Is the Insurance Carrier's denial reason based on preauthorization supported?
2. Is the Requestor entitled to reimbursement for the services in dispute?

Findings

1. The services in this dispute were denied based on preauthorization and utilization review reasons. Specifically, the denial asserts that the body areas treated were not authorized for treatment.

   The CPT codes in dispute are described as follows:

   CPT code 97110 - "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."

CPT Code 97712 – "Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities."

28 TAC §134.600 which sets out preauthorization guidelines for specific treatments and services, states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: … (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
(i) Modalities, both supervised and constant attendance;
(ii) Therapeutic procedures, excluding work hardening and work conditioning;
(iii) Orthotics/Prosthetics Management;
(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code…"

In accordance with 28 TAC §134.600(p), DWC finds that the disputed CPT codes, 97110 and 97112, require preauthorization.

A review of the submitted documents finds that per the utilization review dated August 29, 2023, the therapeutic procedures in dispute were certified/preauthorized for a total of 12 sessions of post-operative physical therapy to be rendered to [body area] between August 28, 2023, and December 26, 2023. A review of submitted medical bills and medical records finds that the requestor documented and billed for fewer than 12 sessions of therapy to the preauthorized body area, between the dates of August 31, 2023, and September 12, 2023.

DWC finds that the insurance carrier's denial based on preauthorization is not supported.

2. The requestor is seeking reimbursement in the total amount of $2,398.10 for the disputed dates of service. DWC has established above that the therapeutic services in dispute were preauthorized and the insurance carrier's denial reason is not supported. Therefore, DWC will adjudicate the maximum allowable reimbursement (MAR) for the disputed therapeutic services rendered on five dates of service, August 31, 2023, through September 12, 2023.

   The fee guidelines applicable to the services in dispute are found at 28 TAC §134.203, which states in pertinent part, "(a)(5) 'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   Medicare Claims Processing Manual Chapter 5, 10.3.7-effective June 6, 2016, titled Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services, states:

   > Full payment is made for the unit or procedure with the highest PE payment.
   >
   > For subsequent units and procedures with dates of service prior to April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment is made for the PE for services submitted on professional claims (any claim submitted using the ASC X12 837 professional claim format or the CMS-1500 paper claim form) and 75 percent payment is made for the PE for services submitted on institutional claims (ASC X12 837 institutional claim format or

Form CMS-1450).

For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.

To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services.

When the highest PE RVU applies to more than one of the identified services, contractors shall additionally sort and rank these services according to highest total fee schedule amount, and price the service with the highest total fee schedule amount at 100% and apply the appropriate MPPR to the remaining services.

Review of the Medicare policies finds that the multiple procedure payment reduction (MPPR) applies to the Practice Expense (PE) of certain time-based physical therapy codes when more than one unit or procedure is provided to the same patient on the same day. Medicare publishes a list of the codes subject to MPPR annually.

The MPPR Rate File that contains the payments for 2023 services is found at: www.cms.gov/Medicare/Billing/TherapyServices/index.html.

DWC finds that CPT Codes 97110 and 97112 are subject to the MPPR policy. The CPT code 97112 is found to have the highest PE/RVU of the therapeutic services billed on the disputed dates of service. Therefore, the first unit of CPT code 97112 will receive full payment and the reduced PE payment will apply to all subsequent units of timed therapy codes performed on the same date of service.

28 TAC §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

There are five dates of service in dispute. On each disputed date of service, the requestor billed for 2 units of CPT code 97112 in the amount of $132.76 and for 6 units of CPT code 97110 in the amount of $346.86.

- MPPR rates are published by carrier and locality.
- Per the medical bills, the services were rendered in zip code 75043; Medicare locality is 11, Dallas, TX.
- To determine the MAR the following formula is used:
  (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR

- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872

- The Medicare Participating amount for CPT code 97112 at locality 11 in 2023, is $34.70 for the first unit and $26.09 for the subsequent units.
- Using the above formula, DWC finds the MAR is $66.38 for the first unit and $49.91 for second unit. Therefore, the MAR for 97112 x 2 units = $116.29.

- The Medicare Participating MPPR discount amount for CPT code 97110 at locality 11 in 2023 is $22.99.
- Using the above formula, DWC finds the MAR for 97110 x 6 units = $263.89.

- DWC finds that the total MAR for 2 units of CPT code 97112 plus 6 units of CPT code 97110 is $380.18 per each disputed date of service.
- DWC finds that the total MAR for all five dates of service in dispute is $1,900.90.
- The respondent paid $0.00.
- Total reimbursement in the amount of $1,900.90 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has established that reimbursement is due in the amount of $1,900.90.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent, Service Lloyds Insurance Co., must remit to the Requestor, Peak Integrated Healthcare, $1,900.90 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 15, 2024
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel*

a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD) and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.